STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365626	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellbrook Health and Rehab	1957 North Lakeman Drive Bellbrook, OH 45305

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident representative interview, staff interviews, and policy review, the facility failed to notify the physician of a resident's pressure ulcer upon admission and failed to obtain treatment orders to treat it. This affected one (#40) of three residents reviewed for pressure ulcers. The facility census was 36.Findings include:Review of the medical record for Resident #40 revealed an admission date of 04/17/26. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus, and atrial fibrillation. Resident #40 discharged to another skilled nursing facility on 04/20/26. Review of an admission Data Collection evaluation, dated 04/17/26, revealed Resident #40 was cognitively intact and required staff assistance with bed mobility, transfers, toilet hygiene, and bathing. The evaluation revealed Resident #40 admitted with pressure ulcer to coccyx which measured five centimeters (cm) in length by 1.0 cm in width with less than 0.1 cm depth. Review of the physician order on 04/17/26 revealed an order for a low air loss mattress. From 04/17/26 to 04/20/26, there was no documentation to support the physician was notified of Resident #40's pressure ulcer or treatment orders were obtained. Interview on 04/29/26 at 1:48 P.M. with Licensed Practical Nurse (LPN) #271 stated she was Resident #40's admitting nurse on 04/17/26. LPN #271 confirmed Resident #40 had a pressure ulcer present upon admission to the facility and she did not notify the physician of the pressure ulcer to obtain treatment orders. LPN #271 stated she applied barrier cream to Resident #40's coccyx upon admission. Interview on 04/29/26 at 2:00 P.M. with Registered Nurse (RN) #235 stated she was the nurse who assisted Resident #40 with discharge to another skilled nursing facility on 04/20/26. RN #235 stated she assisted the certified nursing aide (CNA) with incontinence care for Resident #40 prior to discharge and stated she had not noticed any skin breakdown on his coccyx at that time. RN #235 confirmed she had only assisted the CNA with turning Resident #40 during incontinence care and had not completed a skin assessment prior to discharge. Interview on 04/29/26 at 2:50 P.M. with Resident #40's representative stated Resident #40 was admitted to the facility on [DATE] with a pressure ulcer to bottom which he developed while hospitalized . Resident #40's representative stated she was not notified of any treatment orders for Resident #40's pressure ulcer while at the facility. Resident #40's representative stated the pressure ulcer was still present upon his admission to the other skilled nursing facility on 04/20/26. Review of the facility policy titled Pressure ulcers/skin breakdown- Clinical protocol revised April 2018 revealed the staff, and practitioner would examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. The physician would order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressing (occlusive, absorption, etc.) and applications of topical agents.This deficiency represents non-compliance investigated under Complaint Number 2978515.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, resident representative interview, staff interviews, and policy review, the facility failed to ensure a resident's continuous positive airway pressure (CPAP) was administered according to physician orders. This affected one (#40) of three residents reviewed for respiratory cares and services. The facility census was 36.Findings include:Review of the medical record for Resident #40 revealed an admission date of 04/17/26. Diagnoses included chronic obstructive pulmonary disease, asthma, and atrial fibrillation. Resident #40 discharged to another skilled nursing facility on 04/20/26. Review of an admission Data Collection evaluation, dated 04/17/26, revealed Resident #40 was cognitively intact. Resident #40 had oxygen at six liters per nasal canula and bilevel positive airway pressure (BiPAP) at home settings.Review of Resident #40's hospital discharge orders dated 04/17/26 revealed an order to continue CPAP as directed. The orders indicated Resident #40 discharged from the hospital on [DATE] at 6:01 P.M.Review of Resident #40's physician orders revealed an order dated 04/18/26 to apply home CPAP with six to ten liters of oxygen bleed in (process of adding supplement oxygen into another device's airflow every evening shift. Review of Resident #40's Treatment Administration Record (TAR) revealed the CPAP was applied on 04/18/26 and 04/19/26. There was no documentation in medical record to support Resident #40's CPAP was administered on 04/17/26.Interview on 04/29/26 at 1:28 P.M. with Regional Nurse #261 confirmed the medical record for Resident #40 revealed discharge orders on 04/17/26 for CPAP per home settings. Regional Nurse #261 confirmed the medical record did not contain documentation to support CPAP was administered as ordered or that the nurse notified the physician if the CPAP was not available for use on 04/17/26. Interview on 04/29/26 at 1:48 P.M. with Licensed Practical Nurse (LPN) #271 stated she was Resident #40's admitting nurse on 04/17/26 and confirmed Resident #40 had an order for home CPAP machine to be administered every evening. LPN #271 stated Resident #40's family went home to get the CPAP machine to bring back to the facility on [DATE]. LPN #271 stated the family had not returned by the time she finished her shift at 7:00 P.M.Interview on 04/29/26 at 1:55 P.M. with LPN #266 confirmed she was Resident #40's nurse on the evening of 04/17/26. LPN #266 confirmed Resident #40 did receive oxygen on 04/17/26 but could not recall if Resident #40's family had brought the home CPAP machine in that evening (04/17/26) for Resident #40's use. Interview on 04/292/6 at 2:50 P.M. with Resident #40's representative stated the family had brought the CPAP machine into the facility on the evening of 04/17/26 and the nurse and Respiratory Therapist were made aware. Resident #40's representative stated Resident #40 had called her in the morning on 04/18/26 and informed her that staff had not administered the CPAP machine. Review of the facility policy titled CPAP/BiPAP support, revised March 2015 revealed the purpose was to provide spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen. The policy stated to review the physician orders to determine the oxygen concentration and flow, and the positive end-expiratory pressure (PEEP) pressure for the machine.This deficiency represents non-compliance investigated under Complaint Numbers 2997711 and 2990105.